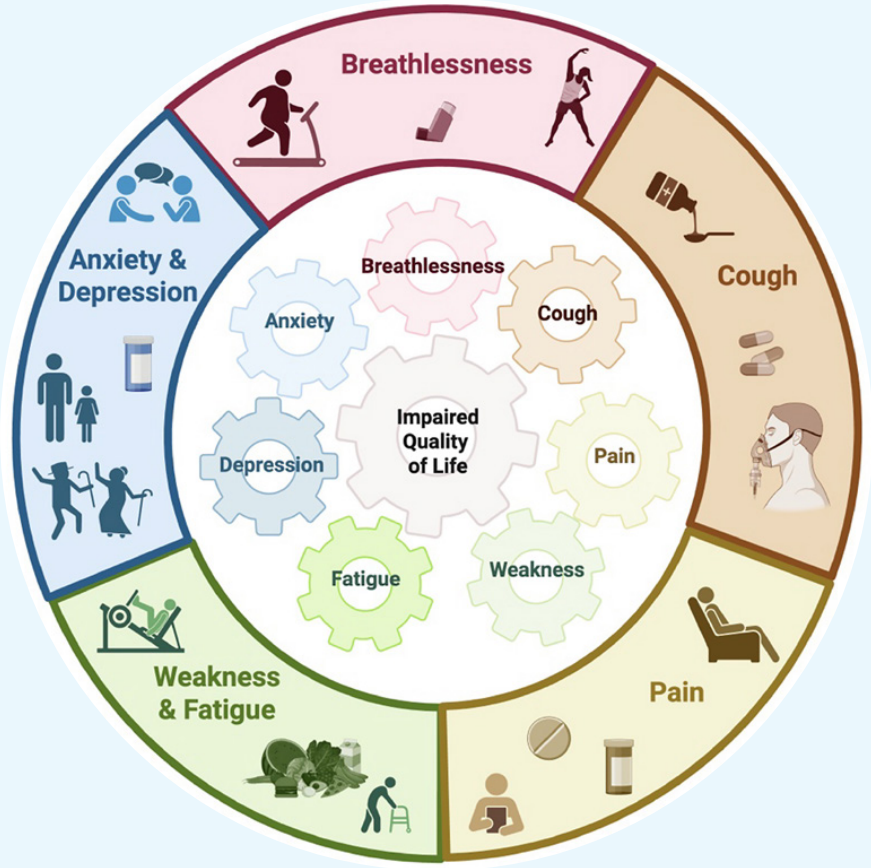
Symptom Management in Serious Respiratory Illness

The burden of symptoms in serious respiratory illnesses (SRI) such as chronic obstructive pulmonary disease (COPD), interstitial lung disease (ILD), chronic bronchiectasis, and others can be a profound experience for patients and their families. Symptoms negatively influence quality of life (QOL), increase health care utilization and contribute to significant health-related suffering. Despite this suffering data demonstrate that people living with COPD rarely receive proactive palliative care support before the end of life (EOL) and are much less likely to receive this care than patients with cancer. While breathlessness may be the most recognizable symptom, clinicians should be aware of other symptoms and their interrelatedness. (Figure).



Symptom burden in SRI.
Symptoms in SRI are interrelated and contribute to impaired QOL and poor health outcomes. Symptoms influence social isolation and loneliness. Treatment options exist for patients for each category of symptoms and are illustrated in the outer circle, with further details in the table below.

This table details a comprehensive approach to assessing and managing symptoms in SRI. Clinicians should consider ways to integrate guideline-recommended symptom assessment tools into routine practice, e.g., during intake and evaluation. We have included several potential pharmacological and non-pharmacological treatment strategies to consider as a holistic approach to symptom management in SRI. Central to symptom management in SRI is ongoing optimization of pulmonary therapies, tobacco cessation counseling, and pulmonary rehabilitation (Table).

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Treatment Strategies for Common Symptoms in SRI		
Symptom	**Assessment Tools**	**Potential Treatment Strategies***
Breathlessness	MMRC, UCSD SOBQ, Borg, CAT, Qualitative description, pulse oximetry	Pulmonary-focused therapies, i.e., inhalers, nebulizers, NIPPV, supplemental oxygen in select cases); low-dose opioids; pulmonary rehabilitation; breathing strategies (diaphragmatic breathing, pursed-lip breathing, visualization); fans; breathlessness action plans for crises; endobronchial valves; lung volume reduction surgery
Cough	CAT	Evaluate for and address extrapulmonary contributors (gastroesophageal reflux disease, chronic rhinosinusitis); airway clearance (nebulizers, cough assist, flutter valve); cough medications (e.g., Benzonatate, Gabapentin); cessation of inhaled substances (tobacco, marijuana, vaping)
Pain	Visual Analog Scale	Antidepressants; opioids and non-opioid management strategies, e.g., non-steroidal anti-inflammatory medications, Gabapentin; physical therapy; acupuncture; cognitive behavioral therapy; massage; referral to pain management specialists as appropriate
Weakness/Fatigue	STOP-BANG	Evaluation for obstructive sleep apnea; hypoventilation (i.e. potential indications for nocturnal positive airway pressures); nutritional evaluation for cachexia and unintentional weight loss; ambulatory assistive devices; increased caregiver support
Depression/Anxiety	PHQ-4, PHQ-9 GAD-7	Antidepressants/anxiolytic medication where indicated; pulmonary rehabilitation; referral to psychology and psychiatry; breathlessness management as above; support groups

Abbreviations: CAT: COPD Assessment Test | **mMRC**: Modified Medical Research Council | **UCSD SOBQ**: University of California San Diego Shortness of Breath Questionnaire | **NIPPV**: Non-invasive positive pressure ventilation | **PHQ**: Patient Health Questionnaire | **GAD**: Generalized anxiety disorder

***** These therapies represent evolving concepts with wide ranging evidence and do not necessarily represent clinical guidelines on treatment. Clinicians should use their discretion and involve interprofessional team members to help manage moderate to severe symptoms. Symptom assessment is critical to gauge severity of symptoms.

When should I consider specialist palliative care referral?

High quality symptom management often involves interprofessional engagement as needed. Knowing when to refer is key and may vary depending on local clinic, hospital, and community resources. Clinicians could consider specialty palliative care referral for physical, spiritual, and psychosocial suffering, refractory symptoms, enhanced care coordination and caregiving needs, complex family dynamic issues, or for comfort-focused approaches to care.

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References: ATS Policy Statement on Palliative Care Early in the Care Continuum among Patients with Serious Respiratory Illness